
Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
Hospice Payment System
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Hospice Care is an elected benefit covered under Part A for a beneficiary who meets all of the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course;
- The individual receives care from a Medicare-approved hospice program; and
- The individual signs a statement indicating that he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Medicare may provide the following hospice services for the terminal illness and related conditions:

- Doctor services;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control or pain relief;
- Home health aid and homemaker services;
- Physical therapy;
- Occupational therapy;
- Speech-language pathology services;
- Social worker services;
- Dietary counseling;
- Spiritual counseling;
- Grief and loss counseling for the individual and his or her family;
- Short-term care in the hospital, including respite care; and
- Any covered medically necessary and reasonable services as identified by the interdisciplinary team.

Medicare will NOT pay for the following services when hospice care is chosen:

- Treatment intended to cure the terminal illness;
- Care from any provider that was not set up by the elected hospice;
- Care from another provider that is the same care that the individual must receive from his or her hospice;
- Services not covered by Medicare; and
- Services that are not medically reasonable and necessary.

CERTIFICATION REQUIREMENTS

For the first 90-day period of hospice coverage, the hospice must obtain a certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary team and the individual's attending physician (if he or she has an attending physician) no later than two calendar days after hospice care is initiated. Only a medical doctor or a doctor of osteopathy can certify or recertify a terminal illness. An attending physician is a doctor of medicine or osteopathy or a nurse practitioner who is identified by the patient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of his or her medical care.

Written certification must be on file in the patient's medical record prior to submission of a claim to

the Fiscal Intermediary and must include:

- A statement that the patient's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation that supports a life expectancy of six months or less; and
- Signature(s) of the physician(s).

If the individual lives longer than six months, he or she is still eligible for hospice care as long as there is recertification of the terminal illness.

ELECTION PERIODS

Hospice care is available for 2 periods of 90 days and an unlimited number of 60 day periods. The individual must waive all rights to Medicare payments for the duration of the election/revocation of hospice care.

The election statement includes the following information:

- Identification of the particular hospice that will furnish care to the individual;
- The individual or representative's (if applicable) acknowledgement that he or she has been given a full understanding of hospice care;
- The individual or representative's (if applicable) acknowledgement that he or she understands that certain Medicare services are waived by the election;
- Effective date of the election; and
- Signature of the individual or representative.

An individual or representative may revoke the election of hospice care at any time. In order to revoke the election, the individual must file a document with the hospice that includes a signed statement that he or she revokes the election of hospice care for the remainder of that election period and the effective date of that revocation. The individual forfeits any remaining days in that election period and his or her Medicare coverage of the benefits waived is resumed.

An individual may change the designation of the hospice from which he or she elects to receive hospice care once in each election period. In order to change the designated hospice, the individual must file a signed statement with both the hospice from which he or she has received care and with the newly designated hospice. The statement includes the following information:

- The name of the hospice from which he or she has received care;
- The name of the hospice from which he or she plans to receive care; and
- Date the change is to be effective.

HOW PAYMENT RATES ARE SET

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit. The daily payments are made regardless of the amount of services furnished on a given day and are intended to cover costs that the hospice incurs in furnishing services identified in patients' care plans. Payments are made based on the level of care required by the beneficiary:

- Routine home care;
- Continuous home care;
- Inpatient respite care; and
- General inpatient care.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each category of care's base rate has a labor share and a nonlabor share. The labor share of the base payment amount is adjusted by the hospice wage index. Base rates are updated annually based on the hospital market basket index.

The fiscal year 2007 payment rates for the period October 1, 2006 through September 30, 2007 increased by 3.4 percentage points of the 2006 payment rates, as depicted in the chart below.

There are two caps that apply to the hospice benefit:

1) The number of days of inpatient care it may furnish is limited to not more than 20 percent of total patient care days; and
2) An aggregate payment amount that is based on the number of Medicare patients electing the benefit within the cap period.

The hospice aggregate cap is adjusted annually by the medical expenditure category of the Consumer Price Index. For the cap year ending October 31, 2006, the cap is $20,585.39.

To find additional information about the hospice benefit, see the Hospice Center Web Page located at **www.cms.hhs.gov/center/hospice.asp**. This web page also contains a link to hospice manual information (Chapter 9 of the ***Medicare Benefit Policy Manual***, Pub. 100-02, and Chapter 11 of the ***Medicare Claims Processing Manual***, Pub. 100-04).

Fiscal Year 2007 Hospice Payment Rates

Code	Description	Rate	Wage Component Subject to Index	Non-Weighted Amount
651	Routine Home Care	130.79	89.87	40.92
652	Continuous Home Care Full Rate = 24 hours of care $31.81 hourly rate	763.36	524.50	238.86
655	Inpatient Respite Care	135.30	73.24	62.06
656	General Inpatient Care	581.82	372.42	209.40

Medicare Contracting Reform (MCR) Update
Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FI) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at **www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

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